Colorectal Cancer Update: Butt Seriously

Jason Domagalski, MD, FAAFP

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Jason Domagalski, MD, FAAFP

Program Director, Medical College of Wisconsin Affiliated Hospitals Community Memorial Hospital Family Medicine Residency, Menomonee Falls, WI

Dr. Domagalski practices family medicine in Menomonee Falls, WI. He provides outpatient and inpatient services. Colon cancer screening, gastroesophageal reflux disease (GERD), and inflammatory bowel disease are his specialty topics. Dr. Domagalski believes that access to endoscopy through primary care is an important trend.
Learning Objectives

1. Screen for colorectal cancer using evidence-based criteria from current guidelines.
2. Utilize documentation of clinical decision tools to foster patient engagement and facilitate shared decision making about CRC screening options.
3. Establish an automated or staff-driven process, to send CRC screening invitations, containing personalized risk-estimates to patients.
4. Coordinate communication with the oncologist, including formal survivorship care plans, to outline follow-up plans for surveillance after polypectomy and CRC resection.

Audit Engagement System

Step 1
Step 2
Step 3
Colorectal cancer represents 8.3% of all new cancer cases in the U.S.

<table>
<thead>
<tr>
<th>Common Types of Cancer</th>
<th>Estimated New Cases 2019</th>
<th>Estimated Deaths 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Breast Cancer (Female)</td>
<td>268,600</td>
<td>41,760</td>
</tr>
<tr>
<td>2. Lung and Bronchus Cancer</td>
<td>228,150</td>
<td>142,670</td>
</tr>
<tr>
<td>3. Prostate Cancer</td>
<td>174,650</td>
<td>31,620</td>
</tr>
<tr>
<td>4. Colorectal Cancer</td>
<td>145,600</td>
<td>51,020</td>
</tr>
<tr>
<td>5. Melanoma of the Skin</td>
<td>96,480</td>
<td>7,330</td>
</tr>
<tr>
<td>6. Bladder Cancer</td>
<td>80,470</td>
<td>17,670</td>
</tr>
<tr>
<td>7. Non-Hodgkin Lymphoma</td>
<td>74,200</td>
<td>19,970</td>
</tr>
<tr>
<td>8. Kidney and Renal Pelvis Cancer</td>
<td>73,820</td>
<td>14,770</td>
</tr>
<tr>
<td>9. Uterine Cancer</td>
<td>61,880</td>
<td>12,160</td>
</tr>
<tr>
<td>10. Leukemia</td>
<td>61,780</td>
<td>22,840</td>
</tr>
</tbody>
</table>


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Top 10 Cancers by Rates of Cancer Deaths

Colons and Rectums, United States, 2016

- Lung and Bronchus: 39.6
- Female Breast: 20.0
- Prostate: 19.4
- Colon and Rectum: 13.7
- Pancreas: 11.0
- Ovary: 6.8
- Liver and Intrahepatic Bile Duct: 6.7
- Leukemias: 6.3
- Non-Hodgkin Lymphoma: 6.4
- Corpus and Uterus, NOS: 5.0

Rate per 100,000 people


Estimated New Cases in 2019: 145,600
% of All New Cancer Cases: 8.3%

Estimated Deaths in 2019: 51,020
% of All Cancer Deaths: 8.4%

Percent Surviving 5 Years: 64.4%
2009-2015

https://fightcolorectalcancer.org/prevent/about-colorectal-cancer/facts-stats/ Accessed June 1, 2019

Rate of New Cancers in the United States
Colon and Rectum, All Ages, All Races/Ethnicities, Male, and Female, Rate per 100,000 people, 2016

### Number of New Cases per 100,000 Persons by Race/Ethnicity & Sex: Colorectal Cancer

<table>
<thead>
<tr>
<th></th>
<th>MALES</th>
<th>FEMALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Races</td>
<td>44.2</td>
<td>33.9</td>
</tr>
<tr>
<td>White</td>
<td>43.4</td>
<td>33.6</td>
</tr>
<tr>
<td>Black</td>
<td>52.4</td>
<td>39.1</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>37.9</td>
<td>26.9</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>41.2</td>
<td>37.9</td>
</tr>
<tr>
<td>Hispanic</td>
<td>40.0</td>
<td>28.8</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>45.0</td>
<td>34.7</td>
</tr>
</tbody>
</table>

SEER 21 2012-2016, Age-Adjusted


### Rate of Cancer Deaths in the United States

<table>
<thead>
<tr>
<th></th>
<th>Colon and Rectum, All Ages, All Races/Ethnicities, Male, and Female, Rate per 100,000 people, 2016</th>
</tr>
</thead>
</table>

Poll Question 1

Mrs. Pam Lee History is a 54 yo F with a multiple family members diagnosed with colon cancer in their 40s and 50s. She asks what percentage of CRC is attributable to a hereditary cancer syndrome?

A. 1-2%
B. 5-10%
C. 15-20%
D. 25-30%


Risk Factors

• 5% lifetime risk of developing CRC
• 90% of cases seen after age 50
• Factors that increase risk:
  • Inherited (HNPCC, FAP)
  • Personal hx of CRC, adenomas, IBD
  • Family hx of CRC or polyps in 1st deg relative
  • Approx 30% of people have these factors

**Associated With CRC**

- Heavy alcohol use
- Obesity
- Cigarettes
- Red meat
- Diabetes
- Acromegaly
- HIV

**ACG Notable Risk Factors**

- Cigarette Smoking
  - Associated with up to 20% of all CRC in US
  - 20 pk-yr history has 2-3x the risk for adenomas
  - Two-fold increase in risk for advanced neoplasia
- Obesity
  - 1.5 - 2.8 fold increased risk of CRC
  - Double the relative risk of adenomas and high risk adenomas
- ACG Recommendation: Special effort warranted to ensure screening in these two groups

CRC Clinical Manifestations

- Asymptomatic
- Abdominal pain
- Altered bowel habits
- Hematochezia
- Melena
- Weakness
- Weight loss
- Iron deficiency anemia


Adenomatous Polyps

- Dysplastic, have malignant potential
- More prevalent with age
- Patients require surveillance colonoscopy
- 25% men, 15% women after age 50
- Increased right-sided adenomas in:
  - Women
  - African-American
  - Elderly

Adenoma Classification

- Glandular histology and level of dysplasia determine malignant potential

<table>
<thead>
<tr>
<th>Adenoma Type</th>
<th>Histology component</th>
<th>Percent of adenomas</th>
<th>Malignant transformation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tubular</td>
<td>Tubular component 75%</td>
<td>80%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Tubulovillous</td>
<td>26-75% villous component</td>
<td>5-15%</td>
<td>19.0%</td>
</tr>
<tr>
<td>Villous</td>
<td>75% villous component</td>
<td>5-15%</td>
<td>38.4%</td>
</tr>
</tbody>
</table>


Adenoma-Dysplasia-Carcinoma Sequence
**Sessile Serrated Polyps**

- Principal precursor of hypermethylated gene cancers
- 20-30% of cancers can arise from this pathway
- Can have cytologic dysplasia (more advanced)
- Difficult to detect – flat, indiscrute, adherent mucous
- Proximal to sigmoid are higher risk
- Size > 10 mm are higher risk
- Appearance resembles hyperplastic


**Adenocarcinoma**

- Colonic masses or pedunculated
- Colonoscopy test of choice for symptoms
- Biopsies and surgical consultation
- Endoscopic features suggestive of CRC
  - Depression
  - Friability or spontaneous bleeding
  - Ulcerations
Adenocarcinoma

Adenocarcinoma
Poll Question 2

Mrs. Anita Test

A 51yo average-risk female comes to your clinic for a well woman exam. She asks you what test she should do to screen for colorectal cancer. Which of the following is NOT recommended by the USPSTF or ACS?

A. Annual fecal occult blood test  
B. Sigmoidoscopy every 5 years  
C. Double contrast barium enema every 5 years  
D. Colonoscopy every 10 years

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<table>
<thead>
<tr>
<th>Society</th>
<th>Guideline Date</th>
<th>Screening Test and Interval</th>
<th>Patient Age (years)</th>
</tr>
</thead>
</table>
| USPSTF                              | 2016           | • High Sensitivity-Fecal Occult Blood Test (HS-FOBT) annually  
• Fecal Immunochemical Test (FIT) annually  
• Flexible Sigmoidoscopy (FSIG) every 10 yrs w/ FIT annually  
• Colonoscopy (Colo) every 10 yrs  
• Stool DNA (sDNA) every 1-3 yrs*  
• CT Colonography every 5 yrs* | Start at 50 end at 75*                                                                                 |
| American College of Gastroenterology (MSTF) | 2017           | First Tier  
• Colo every 10 yrs  
• FIT annually  
Second Tier  
• FSIG every 5-10 yrs  
• CTC every 5 yrs  
• Stool DNA every 3 yrs  
Third Tier  
• Capsule Colonoscopy | Start at 50 OR 45 in AA  
End at 75 or <10 yr life expectancy if prior negative OR 85 if no prior testing |
| American Cancer Society (ACS)       | 2018           | Tests that detect adenomatous polyps and cancer (structural tests)  
• Colo every 10 yrs  
• FSIG every 5 yrs  
• CT Colonography every 5 yrs  
Tests that primarily detect cancer (stool based)  
• HS-FOBT annually  
• FIT annually  
• sDNA interval uncertain | Start at age 45 OR 75  
Through age 75  
76-84 Individualized  
Do not screen >85 |
Differences in Screening Guidelines

• USPSTF
  • Formalized process
  • Generalists and research methodologists
  • Focuses on clinical outcomes
  • Excludes high-risk groups
  • No preference among the tests recommended


Differences in Screening Guidelines

• American Cancer Society
  • 11 clinicians and population health professionals + 1 patient advocate
  • Annual institutional review
  • Based on scientific evidence and systematic reviews

• American College of Gastroenterologists
  • Less formalized process
  • Subspecialists
  • Focuses on prevention and test sensitivity


Available Screening Tests

- Tests that detect adenomatous polyps and cancer
  - Flexible sigmoidoscopy
  - Colonoscopy
  - Double-contrast barium enema*
  - Computed tomography colonography
  - Capsule colonoscopy
- Tests that primarily detect cancer
  - High sensitivity fecal occult blood testing
  - Fecal immunochemical test
  - Stool DNA test


Flexible Sigmoidoscopy

- Complete or partial bowel prep required
- Sedation usually not used (discomfort)
- Views only lower half of colon (last 60cm)
- Concerning findings require colonoscopy
Colonoscopy

- Complete bowel prep
- Moderate sedation - need driver
- Perforation and bleeding risk is higher
- View entire colon and remove polyps

Double Contrast Barium Enema

- Complete bowel prep required
- Polyps require colonoscopy
- Low complication risk
- Replaced by CTC

Computed Tomography Colonography

- Complete bowel prep required
- Colonoscopy for polyps
- Low complication risk
- AKA “Virtual colonoscopy”

Capsule Colonoscopy

- Proximal imaging for incomplete colonoscopies
- NOT FDA approved for average risk individuals
- 88% of adenoma>6mm
- Failed to detect serrated adenomas
- Requires a 2nd more involved prep
High Sensitivity Fecal Occult Blood Testing

- 3 samples collected at home
- Stool from a DRE should not be used
- False +: Avoid ASA, NSAIDs, red meat, poultry, fish, some raw vegetables
- False -: Vit C (blocks peroxidase)
- Sensitivity improves with each sample

Fecal Immunochemical Test

- Detects human globin, not peroxidase
- More specific for human blood
- Less false +
- Fewer samples and handling of stool
- 80 % sensitive

StoolDNA Test

- Tests for known DNA alterations in adenoma-carcinoma sequence
- Adenomas and cancer cells shed altered DNA in the stool
- Uses a multi-target DNA assay to test for many different gene mutations
- High False +
- $$


Mr. Juan Moore-Thing

A 42yo male is new to your practice and you find out that he has a father who was diagnosed with colon cancer at age 55. He asks you the following questions:

- When should I start colon cancer screening?
- What test should I have?
- How often will I need to be tested?
Screening Based on Risk

<table>
<thead>
<tr>
<th>Patient</th>
<th>Initial Age (years)</th>
<th>Interval if normal (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No family history of colorectal cancer</td>
<td>50 (45 in AA)</td>
<td>10</td>
</tr>
<tr>
<td>Single first-degree relative with CRC or</td>
<td>50 (45 in AA)</td>
<td>10</td>
</tr>
<tr>
<td>advanced adenoma diagnosed ≥ 60 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single first-degree relative with CRC or</td>
<td>40 or 10 yrs younger than relative (the earlier)</td>
<td>5</td>
</tr>
<tr>
<td>advanced adenoma diagnosed ≤ 60 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: An advanced adenoma is defined as an adenoma 10mm in size or larger, or with villous elements, or with high grade dysplasia.


Sarfaty, M. How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician’s* Evidence-Based Toolbox and Guide 2008
http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf

Sample Screening Algorithm

Assess Risk: Personal & Family

- Average risk: No family history of CRC or adenomatous polyp
- Increased or high risk based on personal history
  - < 50 years
  - ≥ 50 years
- Do not screen
- Screen

Surveillance: Colonoscopy

If positive, diagnosis by colonoscopy

Options:
- Tests That Find Polyps and Cancer
  - Flexible sigmoidoscopy every 5 years, or colonoscopy every 10 years
  - Double-contrast barium enema every 5 years, or CT colonography (virtual colonoscopy) every 5 years
- Tests That Primarily Find CRC
  - Yearly fecal occult blood test (FOBT), or Yearly fecal immunochromatographic test (FIT), or Stool DNA test (SDNA), interval uncertain

Screening colonoscopy, genetic testing, and other cancer screening as appropriate

Screen with colonoscopy 10 years before youngest relative or age 40

This chart can be viewed at: http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf

*The multiple stool take-home test should be used. One test done by the doctor in the office is not adequate for testing. The tests that are designed to find both early cancer and polyps are preferred if these tests are available and the patient is willing to have one of these more invasive tests.
Poll Question 3

Mrs. Igottapolyp

A 52yo female just underwent her first baseline screening colonoscopy and her pathology returned with 3 “tubular adenomas” all under 1 cm in size. When should she have her next colonoscopy?

A. 1 year  
B. 3 years  
C. 5 years  
D. 10 years

The “State” of Screening

Healthy People 2020

- Goal to reach 70.5% screening
- Lower rates of screening in:
  - Asians: 46.9%
  - Hispanics: 46.5%

National Colorectal Cancer Roundtable

• Joint Initiative CDC and ACS

• Goal of 80% screening by 2018
  • Maine closest 75.9%

• Resources for physicians


Patient Engagement:
“Leading A Horse to Water”

• Create a Collaborative Care Plan
• Address common barriers:
  • Risks of procedure
  • Underestimated risk of disease
  • Option of screening choices
• Tailored interventions more successful
• Documentation of Decision-Making


Comprehensive Discussion

• Explain benefits
• Explain how tests are done
• Explain accuracy of test
• Explain potential test complications
• Ask if patient understands/has questions
• Ask if patient has all needed info


Poll Question 4

Does your practice utilize an Automated or Staff-Driven process to increase CRC Screening?
A. Yes, automated notification
B. Yes, staff-driven outreach
C. No
D. I don’t know
Promoting Improvement in Screening

- Automated notification
  - EHR linked
  - More detailed associated with higher compliance
- Staff-driven contact
  - Medical assistant vs RN
- Tailored vs. non-tailored notification

Resources to Boost Screening

National Colorectal Cancer Roundtable
- [http://nccrt.org](http://nccrt.org)
- Manual for Increasing CRC screening Rates
- Toolbox for physicians
- EHR linked

Colon Cancer Risk Calculator
Poll Question 5

Mrs. Priya Venshun is a 56 yo F interested in any medication that may reduce risks for developing colon cancer. Which of the following is true in regards to the USPSTF recommendations on Aspirin and colorectal cancer? It is recommended for only adults > 60 with a life expectancy of 5 + years

A. It is recommended for adults >50 with a life expectancy of 10+ years
B. It is Not recommended for any adults for CRC prevention
C. It is recommended only for adults with a Family history

Aspirin and CRC

| Table 1: Aspirin Use for the Primary Prevention of Cardiovascular Disease and Colorectal Cancer: Clinical Summary of the USPSTF Recommendation |
|-------------|-----------|-----------|-------------|-----------|
| Population  | Adults aged 50 to 59 years with a ≥10% 10-year CVD risk | Adults aged 60 to 69 years with a ≥10% 10-year CVD risk | Adults younger than 50 years | Adults aged 70 years or older |
| Recommendation | Initiate low-dose aspirin use, Grade C | The decision to initiate low-dose aspirin use is an individual one, Grade C | No recommendation. Grade C (insufficient evidence) | No recommendation. Grade C (insufficient evidence) |
| Risk assessment | Primary risk factors for CVD are older age, male sex, hypertension, abnormal lipid levels, high blood pressure, diabetes, and smoking. Risk factors for colorectal cancer include a family history of colon polyps, a personal history of polyps or colorectal cancer, a personal history of adenomatous polyps, and a personal history of inflammatory bowel disease. |
| Preventive medication | Aspirin's antiplatelet effect is useful for primary and secondary CVD prevention because it potentially decreases the accumulation of blood clots that form as a result of reduced blood flow at atherosclerotic plaques, thereby reducing tissue damage to heart and brain tissue. The mechanisms for inhibition of adenoma or colorectal cancer development are not yet well understood but may result from aspirin's anti-inflammatory properties. |
| Treatment and dosage | A reasonable approach consistent with the evidence is to prescribe 81 mg per day (the most commonly prescribed dose in the United States), and assess CVD and bleeding risk factors starting at age 50 years and periodically thereafter, as well as when CVD and bleeding risk factors are first detected or change. |
| Balance of benefits and harms | The benefits of aspirin use outweigh the increased risk of bleeding in a moderate amount. | The benefits of aspirin use outweigh the increased risk of bleeding by a small amount. | The evidence on aspirin use is insufficient and the balance of benefits and harms cannot be determined. | The evidence on aspirin use is insufficient and the balance of benefits and harms cannot be determined. |
Table 3. Lifetime Events in 10,000 Women Taking Aspirin*

<table>
<thead>
<tr>
<th>CVD risk</th>
<th>Nonfatal MIs prevented</th>
<th>Nonfatal ischemic strokes prevented</th>
<th>CRC cases prevented</th>
<th>Serious GI bleeding events prevented</th>
<th>Hemorrhagic strokes prevented</th>
<th>Net life-years gained</th>
<th>QALYs gained</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aged 50 to 59 years</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10%</td>
<td>148</td>
<td>137</td>
<td>139</td>
<td>209</td>
<td>35</td>
<td>219</td>
<td>621</td>
</tr>
<tr>
<td>15%</td>
<td>150</td>
<td>143</td>
<td>135</td>
<td>200</td>
<td>34</td>
<td>334</td>
<td>716</td>
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<tr>
<td>20%</td>
<td>152</td>
<td>144</td>
<td>132</td>
<td>184</td>
<td>29</td>
<td>463</td>
<td>833</td>
</tr>
<tr>
<td><strong>Aged 60 to 69 years</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10%</td>
<td>101</td>
<td>116</td>
<td>105</td>
<td>230</td>
<td>32</td>
<td>--12</td>
<td>284</td>
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<tr>
<td>15%</td>
<td>110</td>
<td>129</td>
<td>93</td>
<td>216</td>
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<td>111</td>
<td>130</td>
<td>97</td>
<td>217</td>
<td>33</td>
<td>48</td>
<td>360</td>
</tr>
</tbody>
</table>

CRC = colorectal cancer; CVD = cardiovascular disease; GI = gastrointestinal; MI = myocardial infarction; QALY = quality-adjusted life-year.

*--A complete set of results is available in the decision analysis report (see reference 28 in the original recommendation statement at http://www.uspreventiveservicestaskforce.org/).

Table 2. Lifetime Events in 10,000 Men Taking Aspirin*

<table>
<thead>
<tr>
<th>CVD risk</th>
<th>Nonfatal MIs prevented</th>
<th>Nonfatal ischemic strokes prevented</th>
<th>CRC cases prevented</th>
<th>Serious GI bleeding events prevented</th>
<th>Hemorrhagic strokes prevented</th>
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<th>QALYs gained</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aged 50 to 59 years</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10%</td>
<td>225</td>
<td>84</td>
<td>139</td>
<td>284</td>
<td>23</td>
<td>333</td>
<td>588</td>
</tr>
<tr>
<td>15%</td>
<td>267</td>
<td>86</td>
<td>121</td>
<td>260</td>
<td>28</td>
<td>395</td>
<td>644</td>
</tr>
<tr>
<td>20%</td>
<td>286</td>
<td>92</td>
<td>122</td>
<td>248</td>
<td>21</td>
<td>605</td>
<td>834</td>
</tr>
<tr>
<td><strong>Aged 60 to 69 years</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10%</td>
<td>159</td>
<td>66</td>
<td>112</td>
<td>314</td>
<td>31</td>
<td>--20</td>
<td>180</td>
</tr>
<tr>
<td>15%</td>
<td>186</td>
<td>80</td>
<td>104</td>
<td>298</td>
<td>24</td>
<td>96</td>
<td>309</td>
</tr>
<tr>
<td>20%</td>
<td>201</td>
<td>84</td>
<td>91</td>
<td>267</td>
<td>27</td>
<td>116</td>
<td>318</td>
</tr>
</tbody>
</table>

CRC = colorectal cancer; CVD = cardiovascular disease; GI = gastrointestinal; MI = myocardial infarction; QALY = quality-adjusted life-year.

*--A complete set of results is available in the decision analysis report (see reference 28 in the original recommendation statement at http://www.uspreventiveservicestaskforce.org/).
Poll Question 6

Mrs. Ann T Oxidant is a 44 yo F who is relatively healthy and has questions in regard to antioxidants as prevention of colon cancer. Which of the following is true in regards to the current research on antioxidants?

A. Diets high in fruits and vegetables reduce CRC rates
B. Vegetables not fruit reduced rates in older chinese men
C. One study showed high dose Vitamin E was associated with a reduced rate of CRC in women
D. Vitamin E reduced CRC in men only

Antioxidants

- Pro-oxidants theoretically induce DNA damage
- Fruits/Vegetables mixed evidence
  - No protection in US cohorts
- High intake of Vitamin E protective
  - Iowa Women’s Health Study
- Vitamin E not protective for CRC in men
  - SELECT trial
  - Increased rate of prostate cancer
Survivors

Based on data from SEER 18 2009-2015. Gray figures represent those who have died from colorectal cancer. Green figures represent those who have survived 5 years or more.

https://fightcolorectalcancer.org/prevent/about-colorectal-cancer/facts-stats/, Accessed June 1, 2019
Number of Deaths per 100,000 Persons by Race/Ethnicity & Sex: Colorectal Cancer

<table>
<thead>
<tr>
<th>MALES</th>
<th>FEMALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Races</td>
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U.S. 2012-2016, Age-Adjusted

Survivorship Care Plans

- Proposed by IOM
- Summarized Treatment History
- Recommendations for Ongoing Care
- Listing of Practical Survivorship Resources
- Initiated by primary cancer treatment provider and carried out as a team


Survivorship Care Essentials

- Prevention
  - Recurrence or new cancer
- Surveillance
  - Cancer spread or medical/psychosocial effects
- Intervention
  - For consequences of cancer
- Coordination
  - PCM and specialist
Practice Recommendations

• Comprehensive discussions addressing benefits/risks, complications of testing and susceptibility to disease should be included in routine health maintenance. (SOR: B)

• Do not repeat CRC screening for 10 years after a high-quality negative colonoscopy in average risk individuals. (SOR:C)

• Survivorship Care Plans should be developed to assist in the post treatment management of Colorectal Cancer Survivors (SOR:C)

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Questions

References